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Topeka
Kansas

Issued bi-monthly by the Menninger Foundation, Topeka, Kansas.
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BULLETIN of the
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VOLUME 12 MARCH, 1948 NUMBER 2

SPONTANEOUS REGRESSION ON THE INDUCTION OF HYPNOSIS*

By MERTON M. GILL, M.D.

This case of spontaneous regression on the induction of hypnosis is presented with two aims in view: first, to see its bearing on problems of hypnotic regression; and second, to discuss regression more generally. Regression is here being used in its meaning of the spontaneous or induced re-living in the present tense of a specific previous episode in the life of an individual, not in its more general psychopathological meaning.

First, a brief description of the case: the patient was a 34-year-old white married male, ex-Navy petty officer, in civilian life a highway patrolman. He entered the hospital with functional digestive complaints, sub-occipital headaches and urinary frequency, all of two and a half years' duration. The symptoms began while he was abroad in the Navy, at a time when he was troubled by guilt feelings over his first extramarital affair and by a conflict with his superior officer. There had been an exacerbation of his illness since his return to civilian work some nine months before admission, with feelings of inadequacy, a suspicion that others were watching him critically and preoccupation with memories of various scenes of violence and horror he had witnessed during his police work.

Physical examination revealed no organic pathology. Psychological tests and psychiatric examination concurred in describing a moderate decompensation of a severely obsessional character. To figures of authority in the hospital the patient displayed an eager compliance, so extreme as to be almost ludicrous. The patient was treated by the usual hospital special therapies and by superficial expressive psychotherapy, some of it in connection with the material obtained in hypnotic interviews. He was discharged after three and a half months, apparently restored to his former compulsive defenses.

The patient was first hypnotized during a group hypnotizability study. He had been twice hypnotized during his 'teens by vaudeville artists. He seemed to go quickly into deep hypnosis and shortly began to sob and moan. Several attempts to get him to talk failed, and he was awakened by com-

* Read at the meeting of the American Psychiatric Association, New York City, May 22, 1947.

mand. When later seen individually, he had amnesia for the events in hypnosis except that he vaguely recalled considerable emotional distress, and it was only with reluctance that he agreed to be hypnotized again.

The next induction of hypnosis was marked by signs of extreme agitation, with very rapid shallow breathing. After some moments the patient again began to sob and moan. Attempts to communicate with him failed until he was finally heard to mutter that he was very tired and something about "George." It then occurred to the writer that the patient was spontaneously regressed; he asked the patient to whom he was talking, found himself identified as George, a friend, and was able to elicit the story of what was taking place. The patient had previously told about obsessively recurring thoughts of a horrible scene he had encountered 14 years before. In the regressed state he now confessed to his friend George something which he had actually never before revealed to anyone. On the occasion of this scene, the patient had been guilty of a serious neglect of duty amounting to a crime. It is to be presumed that during the intense agitation he had re-lived the horrible scene, but this could not be absolutely established because it was impossible to get him to say anything during that agitation.

During the next few weeks the patient was hypnotized some 10 times more. The following are the observations made which seem the most important from the point of view of hypnotic regression.

First: Until the last few times, each time the patient was hypnotized he went into a spontaneous regression. The last few times he was instructed during induction to remain in present orientation. He did so, but with a marked tendency to lapse into a regression.

Second: Most of the regressions were to traumatic episodes. The one already described was repeated on the second induction of hypnosis. The others were to different episodes. Some of the regressions were to apparently innocuous episodes. Except for the first time in the group, the episodes were always innocuous if the situation in which the patient was hypnotized was one which would make him uneasy. An example of such a situation was his being hypnotized with several other people present, while electroencephalography was being done on the patient.

Third: Although great difficulty was sometimes encountered, the patient could be made during a regression to respond to a motor suggestion entirely unrelated to the events of the regression. On one such occasion, though the suggestion was successful, the patient's eyes opened; and although he remained in hypnosis, he was no longer in regression.

Fourth: During a regression, the patient answered questions about events subsequent in time to the regression.

Fifth: The patient could be brought out of hypnosis from a regression

by telling him, without any attempt first to reorient him to the present, that the therapist would say the letters from A to G, and he was to awaken at G.

Sixth: Questioning after each letter from A to G during the termination of hypnosis revealed that with the letter A, the patient became confused and disoriented for time, person and place, remaining so until the letter G, when he awakened, oriented without confusion in the present.

Before discussing the significance of these findings, we will turn for a moment to the literature on regression.

Spontaneous regression on the induction of hypnosis has, so far as the writer knows, been described in recent years only in connection with the traumatic neuroses of war.[1, 2] The spontaneous development of states of regression in which, in an hypnotic-like state, the patient re-lived traumatic episodes seems however to have been at one time a rather common psychiatric phenomenon. The famous case of Anna O. in Breuer and Freud's *Studies in Hysteria*[3] showed such phenomena as did many cases described by Janet[4] and others around the turn of the century. Janet called them "monoideic somnambulisms." The relationship of such cases to regression on the induction of hypnosis and the reasons for the disappearance of such cases from our clinical material are fascinating unanswered problems.

In our work with hypnosis at the Clinic we have seen only two instances of spontaneous regression on the induction of hypnosis in cases whose presenting problem was not that of a traumatic neurosis. One of the cases is here described, and the other is the case of a woman who on the second induction of hypnosis spontaneously regressed to a traumatic automobile accident 15 years before. This accident seemed of no special moment in her current illness, and subsequent hypnoses with her were unaccompanied by regression.

Although there have been several recent experimental investigations of psychological testing during induced hypnotic regression, the major reference point for discussions of the phenomenon is the work of Erickson and Kubie.[5] In 1941 they introduced into the field a theoretical distinction between states of "regression" and states of "revivification."

Regression they described as "a half-conscious dramatization of the present understanding of that previous time" and revivification as "the type of time regression in which the hypnotic situation itself ceases and the subject is plunged directly into the chronological past." It is difficult to believe that they could have meant this literally, since the concept of an actual psychological return to the past with the wiping out in any dynamic sense of all subsequent experience seems indefensible. If the hypnotic state is indeed terminated during revivification, how is it possible for the hypnotist to regain rapport with the patient to be able to make suggestions for reorientation, suggestions which must be given in hypnosis if they are to

be effective? The possible argument that rapport is re-established by a previously arranged signal is an admission of a persisting tie to current reality.

In our case of the man cited above, there were evidences that ties to current reality persisted despite the regression. First, the patient could be awakened without any suggestions for reorientation. No signal could have been given since the regression was entirely unexpected. Second, when the patient was in an unfamiliar situation he regressed to an innocuous rather than a traumatic episode. Third, in a private session with the therapist the patient confessed a serious crime; he must somehow have been aware that he was in a situation where he could do so without punishment. Fourth, the patient in the state of regression answered questions about events subsequent in time to the regression.

That a real and far-reaching change did take place, however, in the regression is shown by the following evidence: first, the patient spontaneously identified the therapist as a friend he had had during the period to which he had regressed; second, the confusion and disorientation which the patient showed during termination of the hypnosis indicated that during the regression his ego had almost completely reoriented itself to a previous time and place; third, it was very difficult to get the patient to respond to or even to remember motor suggestions made to him by the hypnotist which were not relevant to the events of the past which he was experiencing.

This instance of spontaneous regression bears on the theoretical question of the "genuineness" of hypnotic regression. If by "genuine" regression one means a state such as was described as revivification, we feel there is no such thing; but if by genuine regression one means a significantly altered ego state, oriented to and integrated in a previous time in the patient's life history, but with retention of a relationship, conscious or unconscious, to current reality, this case shows that such a state can develop spontaneously on the induction of hypnosis. This spontaneous regression showed many features described in accounts of induced hypnotic regression. It is true that some instances of induced regression are more "complete" than the one here described and that in them inconsistencies as glaring as answering questions about matters subsequent in time to the regression do not occur. The reasons probably lie in the careful instructions with which such states are induced.

An attempt to understand the nature of regression leads naturally to a consideration of the condition in which spontaneous regression occurs frequently, the traumatic neurosis of war. The regression takes place under three different conditions: first, spontaneously in sleep in one of the characteristic types of battle dreams; second, on the administration of certain

chemical agents—intravenous barbiturates, ether, alcohol and others—; third, on the induction of hypnosis; and fourth, as in some cases described by Fisher,[6] on meeting a situation which is in some significant way reminiscent of the original trauma. In this last war hypnosis was used relatively little, as compared with drugs, but where used—as by Kaufman[1] on Okinawa—the experience of the first World War is confirmed. Men suffering from a recent traumatic neurosis are almost universally easily hypnotized and the induction of hypnosis is often followed by regression to the traumatic episode.

In explaining the phenomenon of regression, discussions often fail to distinguish clearly between the phenomenon itself and its possible therapeutic value. Even the term "abreaction" refers not only to the re-living of a traumatic episode but to the idea that the re-living is of therapeutic value. We will here concern ourselves only with the reasons the regression takes place, not with its possible therapeutic results.

The generally accepted explanation is that the ego exerts an inhibitory action on the emergence into consciousness of both the ideational and and emotional aspects of the memory of the traumatic experience. In instances where this inhibition is most vigorously at work, there is complete amnesia for the episode. Anything which weakens the inhibitory forces of the ego may allow the more complete emergence into consciousness of the experience, which, for reasons about which there is considerable dispute, seems to push toward entrance into consciousness. Battle dreams occur in sleep, a psychophysiological state in which there is a lessening of ego inhibition. In the use of drugs, physiological factors are regarded as initiating the process, the weakening of ego function being due to the toxic action of the drug on the cortex, though the relationship between therapist and patient is also important. In hypnosis the relationship between therapist and patient somehow leads to the diminution of the ego resistances.

Grinker and Spiegel[7] offer a somewhat different explanation for the action of intravenous barbiturates in producing a return to consciousness of the traumatic experience. It derives from their conception of a phasic relationship between diencephalon and cortex in which diencephalon excites cortex and cortex inhibits diencephalon. They argue that the hypothalamus is acted upon relatively more strongly by the barbiturates than is the cortex and that therefore the cortex emerges as relatively stronger in inhibitory capacity than it was before. This is expressed in psychological terms by saying that the ego becomes relatively stronger, the anxiety against which it is defending itself relatively weaker, and the ego can therefore face the traumatic experience and re-establish its discriminatory functions. According to their theory, the traumatic memory emerges into consciousness

because pentothal alters the disposition of forces in a way which makes the ego now strong enough to face it, not, as in the usual theory, because the ego is too weak to prevent it.

We will cite two lines of evidence for the contention that the correct formula is that the ego is too weak to prevent the return of the traumatic experience. The first is that the traumatic experience will return through the use of drugs like alcohol, ether and nitrous oxide, whose action is conceded to be primarily toxic to the cortex. The second is the phenomenon of regression itself. It must first be pointed out that while the theory of weakened ego inhibition accounts for the return of inhibited material to consciousness, it fails to account for the reasons that the material sometimes returns as a memory and is told in past tense and sometimes returns as a regression told in the present tense. Some explanatory factor in addition to lessening of ego resistance is necessary to account for the phenomenon of spontaneous regression. That explanatory factor can be found in the generally accepted differentiation between the defensive and the synthetic functions of the ego. The repression of a painful experience is accomplished by the ego in its defensive function; orientation in time, on the other hand, is a synthetic ego function. The recognition of an experience as in the past requires a simultaneous grasp of the memory of the past and the reality of the present. In a regression the weakening of synthetic ego function results in a weakening of the tie to present reality.

Two lines of clinical evidence lead to the conclusion that if something be done to weaken ego functioning, both defensive and synthetic functions will weaken together. The first is that regression is most likely to appear in the combat neurosis in which there has been complete amnesia. The second is that regression is the more likely to appear, the more intense the emotional and motor discharge in the return of the traumatic episode. Both the lifting of amnesia and vivid emotional and motor discharge must require the greatest diminution in the ego defenses. Concomitantly there is the greatest diminution of the synthetic ego function, resulting in the phenomenon of regression. Spontaneous regression, then, is to be explained as the result of the simultaneous weakening of the defensive and synthetic functions of the ego. Kubie and Margolin[8] have expressed a similar point of view by saying, "Thus drugs can assist both in the lifting of repressions and in the controlled reproduction of the state of ego disorganization which occurs at the time of the original dissociation."

According to their view, however, the living out of the memory in the present tense is a reproduction of the original experience. As a matter of fact, abreaction often differs markedly from the original experience in that affective and motor discharge are much more violent than they were in the original experience. We would say, then, that the re-enactment takes place

in the present tense not because it is a reproduction of the original experience but because with the weakening of the ego which permits the experience to return to consciousness there is a diminution of the synthetic ego function. It seems probable that a vicious circle is set up with violent affective and motor discharge itself leading to still further loss of synthetic ego capacity.

How regression induced by hypnosis may differ from that in which drugs are employed is an unsolved problem. We would like to ask, however, whether it is possible that the change in ego functioning in hypnosis may be regarded as an *abdication*, as compared with the forceful dethronement produced by drugs. Is it possible that with such an abdication there can be a more selective alteration in ego functioning, so that synthetic capacities are not as much weakened as are the defensive functions? It could be argued that in the hypnotic state, the patient "borrows" ego strength by alliance with the hypnotist, and that this added strength permits the weakening of the defensive function so that the repressed material can emerge. For regression to take place, however, the synthetic function must still be relatively weak. If this is indeed the state of affairs in hypnosis, it has important implications from the point of view of therapy, and explains the clinical fact that regression and abreaction in hypnosis can be better controlled by the therapist than regression induced by drugs.[9]

The disturbed orientation of the ego to current reality is an alteration of ego state seen in its most extreme form in regression but occurring in many lesser degrees. Some soldiers will respond to hypnosis or pentothal with a description of the traumatic experiences with alternations from past to present and back again. Even where the description is entirely in the past tense, all degrees of absorption in the experience with concomitant withdrawal of interest from current reality can be seen.

In a recent paper from this Clinic,[10] hypnosis was characterized as an altered state of ego functioning. The functions described and their changes were: first, self-awareness with changes in orientation in space and in body image; second, the mode of thinking with change from logical abstract thinking toward symbolism and visual imagery; third, the repression of affect is weakened; fourth, the inhibition of motor discharge of affect is weakened.

Spontaneous regression on the induction of hypnosis reveals these changes in ego function in extreme form. Vivid visual imagery and strong affective and motor discharge will appear. Change in self-awareness takes place in relation to orientation in time rather than orientation in space. There is a maximal withdrawal from contact with current reality.

Our discussion leaves unanswered many problems about spontaneous regression in general and about this case in particular. To give a few: What is the relationship of traumatic experience to regression? Why are

spontaneous regressions on the induction of hypnosis so rare except in recent acute traumata? Are there any differences between the spontaneous regressions induced by drugs and those initiated by hypnosis? Why did this patient not spontaneously return in any particular hypnotic session to orientation in the present after he had re-lived the traumatic scene? Why did he continue to show spontaneous regression even to apparently innocuous episodes?

Work in hypnosis with veterans who have had traumatic neuroses may help to solve some of these problems.

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A NOTE ON THE INDICATIONS FOR THE USE OF HYPNOSIS IN PSYCHOTHERAPY: AN ILLUSTRATIVE CASE REPORT*

By MARGARET BRENMAN, PH.D and
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The thesis of this presentation is that hypnosis is not and should not be considered an independent "kind" of psychotherapy nor a procedure which should be "engrafted" to any therapeutic relationship mechanically. Rather it should be regarded as a special sort of inter-personal relationship which may be used in countless ways and with utmost flexibility as a tool in the course of a psychotherapy, the precise time and mode of application to depend on the nature of the problem, the current psychodynamic balance and the therapeutic aims being pursued. The current clichés regarding hypnosis are that it has some value in the removal of symptoms by direct suggestion or that it is helpful in eliciting additional material from the patient. It has been our experience, however, that hypnosis may hold somewhat different meanings for different patients and that these different "meanings" may be successfully exploited to advance the therapeutic process.

To the severely regressed patient with *anorexia nervosa* it may constitute at a given moment the significant "magic gesture" which Eisler[1] has described—to be used only once, perhaps in order to establish contact with the patient. To the rigidly inhibited patient, it may be "permission" to speak aloud his usually tabooed thoughts. To the panic-stricken early schizophrenic it may offer at the outset the unqualified parental protection which he must have, with no attendant demands for more information from him. Although it is likely that some "least common denominator" underlies all of these, the specific variations are sufficiently significant to alter the practical applications. We propose to illustrate our thesis with a case report.

The patient was a kindergarten teacher in her late thirties who came for diagnosis and treatment of an illness which, in the fourteen months preceding her admission to the hospital, had become acute with unremitting anxiety, frequent uncontrollable sobbing and a constant necessity to have a member of her family or a close friend by her side. Her anxiety would become even more intense when she would leave her house or in situations where she felt either "hemmed in" or insufficiently protected by her companion. These clear-cut phobic symptoms suggested initially a diagnosis of anxiety hysteria. However, further clinical study together with psycho-

* Read at the meeting of the American Psychiatric Association, New York City, May 21, 1947.

logical test findings brought out material which pointed to an underlying schizophrenic process, with a distinct paranoid flavor. She would constantly accuse her hospital doctor of tricking her in various ways and felt that both patients and staff members were purposely trying to make her feel inferior. When presented with a Thematic Apperception Test picture and asked to "make up a story", she remarked: "I haven't any idea who the woman could be in the doorway, unless it was an old friend of ours who lived down the road."

The crucial point of the patient's illness could be quickly related to a few significant historical facts. She was the eldest daughter of a family of seventeen children and she began very early to take the role of a mother to the rest of the siblings, washing, ironing and sewing for all of them. She apparently dealt with her own needs "to be taken care of" and protected by denying them utterly even to herself, ministering instead to the needs of her brothers and sisters. Her mother rather bitterly and not too inaccurately regarded herself as a "reproductive machine" and the patient's sister commented ironically to the examiner that the father was usually away from the home for long periods and would come home to see the new baby and re-impregnate the mother.

The patient thought of her childhood largely as a period in which she always had to explain to other children that she couldn't go on a picnic or a hike because she had to wash or iron. She accepted this stoically, however, and was usually not aware of much resentment of her mother's serial pregnancies until her adolescence. At that time, the first evidences of her underlying feelings came in the form of a vague antipathy toward the unborn children and some hostility toward her father. When she was brought in to see the thirteenth new baby she averted her head and would not even look at it for over a week. When finally she did consent to see this most recent arrival she was overwhelmed with feelings of deepest tenderness and this child at once became her favorite. She was still sufficiently capable of establishing an adequate defense against her intense hostility and envy of the protected "little ones" to turn her anger into its opposite. We can suppose that it must have been especially difficult to maintain this defense of maternal devotion in the face of the mother's constant expressions of rage and disgust at having so many children—and her statement that she would rather see her children dead than to have them endure an existence such as hers.

However, the patient managed to keep a relative equilibrium, did well in school and decided to prepare herself for a career as a kindergarten teacher, a profession in which she would again directly assume a maternal role. She never went very far from home and maintained an intense involvement in all of the affairs of her brothers and sisters. When the patient was in her

late teens, her mother died shortly after her seventeenth pregnancy, leaving the patient with the instruction that now it would be her job to see that the children were taken care of. This was only a short step for the patient; she assumed almost total responsibility, consulting with her father about financial details and mapping out the lives of her siblings, helping them choose professions and mates.

Like many eldest sisters who assume this role, our patient might well have managed a fairly comfortable though narrow existence had it not been for the fact that at this time, a mis-mated man twenty-five years her senior began to take an active interest in her. As the principal of her school he was necessarily with her frequently and in a position to help her. If one were to construct a human laboratory situation in which the aim of the experiment was to demonstrate the breakdown of a reaction-formation against dependent needs, one could not devise a more effective set of circumstances than were now provided by the patient's association with this man. He showered her with extremely expensive gifts and offered his aid at every turn. He gave her the use of a car, gave her access to large sums of money, provided her regularly with rare foods and drink and even found for her the most skilled beautician available in their small New England city. Although at first the patient assumed the role of protege, this gradually developed into that of sexual partner. This latter, however, was attended by intense guilt and at the same time the patient's conflict regarding her dependence on this man began slowly to develop. She refused many of his offers of money and material objects and, after eight years of this association, made one great effort to get away from him by joining the Red Cross.

Apparently it was too late by this time because during her brief service with the Red Cross, her phobic symptoms began to appear although the acute period of her illness did not commence until almost three years later on the occasion of a visit to her "favorite sister", recently married, at whom it will be recalled she had refused even to look when she was born. At this time, her anxiety became so acute and her sobbing spells so extreme that she had to be hospitalized in her home town and was treated by a local psychiatrist. After a short time she improved enough to return to work but broke down again after a visit from this same sister and again had to be hospitalized. She continued in treatment but this time did not improve and was finally referred to the Menninger Sanitarium by her therapist who felt that she could not be successfully treated at home where she was surrounded by her sixteen siblings and constantly made freshly anxious by her lover. It had come to the point where she felt she had to see her therapist every day, including Sundays and holidays—sometimes twice a day—and required the service of a full-time nurse who could not leave her alone for a minute at a time.

It appears that over the years of association with the older man, her strict defenses against her own intense needs to be taken care of had gradually been worn down, but not in an adaptive fashion. On the contrary, the conflict became more and more intense with each new gift or favor. She had a sense of being trapped and sometimes felt consciously that she had to refuse a specific gift lest she be enchained forever. She was in the constant dilemma of having to weigh the gratification afforded by his largess against the inevitable sense of further helplessness and dependence which his gifts produced. At the same time, she began to realize dimly the man's extreme dependence on her, and in subtle ways "cracked the whip" over him. It appeared from her accounts and those of her sisters that her lover's excessive and sometimes even absurd generosity was his major and somewhat desperate technique for insuring emotional "returns." By the time she came to the Sanitarium, her defenses had all but crumbled and she was literally behaving like a helpless terror-stricken child who could not even go to the dining-room unaccompanied and who, by her illness, now imperiously commanded the same kind of attention and care which she had had to give to her many siblings almost all of her life.

Although she tried when she first came to the Sanitarium to maintain a facade of friendliness and accessibility, she was quite unable to discuss any of the details of her relationship with her lover nor her real feelings about it. Questions aroused a distinctly paranoid reaction, with the patient insisting, "That's nobody's business." Although she had not become actually psychotic, her acute anxiety and helplessness made expressive psychotherapy of the sort used by her first therapist quite impossible. It was felt that, at least in the early phase of this treatment, a "psychological atmosphere" of extreme security and yet permissiveness should be established and that an attempt should be made at first to meet the patient's need for complete dependence rather than to attempt to give her immediate insight into its nature: in short, to let her be the "little girl" she had never been. After having tested her hypnotizability and having found her response fairly good it was decided to use hypnosis as an auxiliary. The method used in hypnotizing her was of the sort described by Ferenczi[2] as "maternal." She was, in a sense "soothed" rather than "commanded." No suggestions were given that she change in any way nor that she produce repressed memories. She was simply told she could speak or behave as she wished. Clearly, this "offer" of unqualified protection must have been a two-edged proposition for this patient, inasmuch as it represented, on the one hand, security and permission to be completely dependent, and on the other hand, a further threat to her by now almost vanished defenses against such dependence. It was precisely on this point that her major conflict regarding her lover hinged.

In this initial period, the patient was hypnotized daily and she proceeded to "pour forth" in an extremely emotional and almost incoherent fashion the content of her conflict. She would spend perhaps the first third or half of each session trying to convey the intensity of her sense of panic. She expressed her terror and feeling of helplessness over and over, much like a terrified child. Her voice at these times took on a "little-girl" quality, ranging from a whimper to wild sobbing. She would perspire profusely and talk in great detail of the smallest bodily discomforts, much as a child presents a bruise as his "ticket" for the unqualified love and attention of an adult. Sometimes she would speak in a cryptic and highly symbolic fashion saying for example that her hand was curled like a cup and that this meant she was a blind person begging for pennies or that her feet were like great chunks of ice—meaning she was frightened. At other times she would begin to "act out", while lying on the couch in hypnosis, her intense conflict regarding her relationship with her lover. For example, on one occasion, she felt as if her hands were of themselves rising into the air and waving. When she was questioned about this, she said it meant her wish to wave goodbye to him. During another session, she began to finger the rings he had given her and finally (though still in hypnosis) flung them across the room, asking the therapist to take charge of them. Although it might appear that these symbolic productions and her impulsive behavior during the hypnotic sessions were simply the usual signs of a schizophrenic process, this assumption was not borne out by her normal state productions and behavior. At no time other than in the hypnotic sessions did she express herself symbolically or show so little restraint.

After several weeks, she confessed with much embarrassment that for the last three years she had been carrying in her purse a tiny bottle of water to be used "in case I should get awfully thirsty" and that she had brought it to give to the therapist to keep. She had never actually drunk any of this water which she carried in a nail-polish bottle, marked "H_2O", and apparently regarded it as a kind of magic talisman to ward off the now-dreaded possibility of suddenly finding herself alone and helpless in a bleak and hostile world where no "supplies" would be forthcoming from anyone. She recognized this need for the bottle as an unrealistic attempt to maintain her self-sufficiency but had felt up to this time that she could not relinquish it. It was as if she were trying in this period to transfer from her lover to the therapist the role of "keeper of the supplies" and to thus establish with the therapist the same kind of tyranically dependent relationship which she had with her lover. There can be little question but that the hypnotic relationship encouraged this.

Here again, however, it became clear that her effort to establish this hostile and demanding dependence was attended by great fear and guilt. Even

during the hypnotic interviews, the therapist discussed this conflict with the patient and she began to develop insight which was at first quite evanescent but which was gradually more steadily accepted. As she began to have occasional days when her intense anxiety was somewhat diminished she wanted to leave the grounds for shopping-trips or outings but felt terrified of riding in a bus or even a taxicab where she felt acutely dependent on the driver, and enraged and humiliated by this dependence. It occurred to one of the authors (R.P.K.) that a possible "boost" to the patient's attempt to reach beyond her "little-girl" helplessness and terror of public conveyances might be provided in the form of a "transitional" vehicle: a bicycle. This idea delighted the patient and was one of the first steps in her period of "weaning" from the infantile, unrestrained first phase of the treatment. The subsequent steps in this "weaning process" were not nearly so enthusiastically accepted by the patient.

When the material elicited in the hypnotic interviews became highly repetitious and when it appeared from the daily record that her "panics" in these sessions were not quite in keeping with her by now more realistic and adult behavior in her everyday contacts, the decision was made that the hypnosis be withdrawn gradually. Whereas it had been necessary at the outset to provide a secure and permissive atmosphere in which "anything goes", it now seemed that she had progressed sufficiently for the attempt to be made to renew to some extent her old defenses against her intense wish to be the "helpless one." The continuance of the hypnotic relationship at this point could serve only to deter this re-construction inasmuch as it offered the constant temptation to give in to her passive wishes and to perpetuate precisely the same conflict in relation to the therapist that she had had with her lover. The situation resembled that in which a hurt child continues to sob piteously in the presence of a sympathetic adult long after the initial pain has somewhat subsided, as a means of exploiting his originally genuine anguish, to the end of extracting more demonstrations of love and attention.

Her first reaction to the withdrawal of hypnosis was to go into spontaneous hypnotic states and to continue with her previous whimpering and complaintiveness; she would do this even when the therapist stated explicitly that at this point of the treatment, she was to simply talk in the normal state. The wish to retreat and to abdicate responsibility was dramatically demonstrated by these self-induced hypnoses. However, as the therapist continued to discuss with her first in the hypnotic sessions and later in face-to-face interviews what it was that she was trying to do, the self-induced hypnoses gradually ceased and the patient was able, at least a part of the time, to discuss her conflicts quite directly. She improved sufficiently to take a part-time job and was progressing well until her father died. Then

she fell back and became extremely anxious, although not so severely as when she first came to the hospital. Psychotherapy in the normal state was continued with the aim of helping the patient to revive and consolidate her compulsive defenses against her intense infantile longing for complete dependence. The patient steadily improved but still had strong flurries of anxiety just before her treatment hour. It was felt at this point that further institutionalization like continued hypnosis would operate in a direction counter to the therapeutic aims at that time and both patient and therapist agreed that the experiment be tried of her going home and continuing with supportive psychotherapy at home.

The patient found that her anxiety at home now was even less than it had been in the Sanitarium and her freedom of movement far greater. She was not able to carry a responsible position, but was able to drive her own car and largely manage the house for herself and one of her sisters. At the same time, she became extremely interested in skilled needle-point and was invited to become a partner in a handwork shop. It appeared that she could mobilize her own resources more effectively at this point, when not confronted with the temptation of depending on the therapist. She found it most difficult to establish a new equilibrium with her former lover but has managed to remain very friendly with him without resuming their sexual relationship.

Although this patient is not yet a really well person, her family gratefully compare her present status with her frenzied sobbing and clinging before she was treated. Here, as always in research on psychotherapy, one certainly cannot say that this same result might not have been achieved by other means. One can say only that both authors were convinced that the adjuvant use of hypnosis in the initial phase of this treatment (and its abandonment at the proper time) was an important positive contribution. This conviction is by no means present in all cases where hypnosis is tried as an auxiliary.

CONCLUSION

We have stated the thesis that hypnosis as such cannot be regarded as a separate type of therapy which has highly specific uses and limitations but that its usefulness will depend entirely on its relevance to the problem at hand and that it must always be considered in its psychotherapeutic context. It cannot be said, for example, that hypnosis is useful in the temporary relief of symptoms or in the eliciting of material, but useless in the production of insight. This is actually a meaningless statement. Whether the use of hypnosis is helpful or pointless will depend on how flexibly it is applied and with what attention to the current psychodynamic status of the patient.

In our case report, we have described a border-line psychotic patient whose central conflict lay in her struggle to maintain compulsive defenses against an intense wish to be dependent. It was shown that, whereas at the outset of therapy, when the patient was overwhelmed with acute anxiety, hypnosis could be used as a valuable adjuvant to provide the necessary sense of protection and security, its continued use was contraindicated when after a certain point it appeared to be a deterrent to the rebuilding of the patient's defenses.

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SOME CLINICAL ILLUSTRATIONS OF FREUD'S ANALYSIS OF THE UNCANNY

By MARTIN GROTJAHN, M.D.*

Once in a while every analyst feels compelled to apply psychoanalysis not only to problems of theory, psychoanalytic technique or medical research, but to everyday, or almost everyday, occurrences. While this often may appear to be a pastime, actually it serves an important scientific purpose; it is a combination of intuition (without which psychoanalysis could not exist and progress) with actual psychoanalytic science and knowledge. As Sigmund Freud's work has shown, the analysis of everyday psychopathology may help to clarify fundamental issues within the framework of psychoanalysis.

The phenomenon of feeling uncanny has been made relatively frequently the object of analytic investigation. After Sigmund Freud's[3] original publication in 1919, other authors have contributed, for instance Theodore Reik, in his book, *Surprise and the Psychoanalyst;* Ernest Jones[5] in *The Nightmare* and Otto Rank[6] in *The Double.* Edmund Bergler[2] made the uncanny the subject of a special paper.

The fundamental work was done by Sigmund Freud, who defined the uncanny as a shocklike experience originating in the re-experiencing of something originally well known but later repressed. As an example, Freud quoted the uncanny feeling produced by many of the stories written by E. T. A. Hoffman. According to Freud, the uncanny is one form of anxiety, caused by the return of the repressed. The uncanny sensation is experienced when something that should have remained unconscious is reactivated and felt consciously. The German language gives good expression for the connection between *heimisch—heimlich—un-heimlich.* Freud made a distinct difference between the uncanny as experienced in reality, and the uncanny as produced in literary art. In the latter, a regression is established to the time before reality testing was established.

One of my patients reported the following experience which he felt with an intense sensation of the uncanny: on his way home one early evening, he met an old lady whom he knew through her son. When he asked about the son's wellbeing, she answered in grief-stricken tones, "He is dead." The patient was shocked, mumbled some words of condolence and went on his way, only to run into the son at the next corner, obviously alive and in good health. He felt as though he were confronted with a ghost, and felt an intense sensation of the uncanny. This feeling was easily dispelled

* Los Angeles.

through the subsequent explanation: "As far as my mother is concerned, I am dead, because I married a woman of a different religion."

The analysis showed that the incident suddenly and shockingly activated in the patient the old and long repressed childhood belief that there are ghosts, that it is possible to meet dead people on the street. The old childhood belief in magic-mystic ways of thinking seemed to be verified by reality. Because of the suddenness of this recognition, the feeling of the uncanny is related to a shock. The shock is the sudden recognition of an old childhood trauma coming true. The difference is the degree of anxiety felt in both emotions. In shock, the repressed trauma or threat is repeated; as, for instance, on the battlefield, where an old castration threat suddenly becomes very real and true. The anxiety in the uncanny is more remote and indirect.

Another patient reported the following incident: at a party, the topic of mind-reading was discussed. Someone claimed that he could read the host's mind. The host took twelve table cards, each with the name of a guest on it, and concentrated on them. The names were not visible to the "mind-reader." Ten out of twelve times the "mind-reader" could correctly announce the names on the different cards; he made a mistake only when his own name came up. At the steadily increasing number of correct answers, the patient felt a mounting, tense sensation of the uncanny. His feeling dissolved with the discovery of what had happened: due to his intimate knowledge of all persons involved, the "mind-reader" was able to interpret the host's facial expression which gave him subliminal cues. The host showed on his face of whom he was thinking, a usually unnoticeable process, which, however, was perceived by the "mind-reader."

Here again analysis showed that an old and repressed childhood belief in magic-mystic thinking, this time, *Mind-reading does exist*, was suddenly re-experienced. The child assumes, and frequently seems justified in doing so, that the grown-up can read his mind, his bad thoughts, and know about his secrets and (masturbatory) habits.

The feeling of the uncanny, in a different setting, was described by a medical officer who was called from his room to a ward at the other end of a spread-out hospital. To get there at night he had to use a mile-long corridor, which was absolutely dark. He started out with some concern about the loss of time in case he should have to walk slowly. Soon he found himself actually losing the sense of his bodily self. At first this experience was slightly amusing, then it became uncanny; he felt his ego "localized" in the plantar part of his feet, and there was no outer world left. What he had feared as a child, that the "soul" could leave the body, he suddenly recognized as becoming true; again an old childhood belief became conscious for a short period of time.

As far as the psychopathology of the uncanny is concerned, it is known that compulsive neurotics have a sense of feeling the uncanny in situations where it would hardly be recognized by those further removed from the magic thinking of childhood. Schizophrenic patients often experience the feeling of the uncanny with panicky intensity where no apparent reason for this can be detected. A young schizophrenic soldier said, "The attendant came to the bed next to mine and straightened it out. This made me feel extremely uncanny." The uncanniness of this situation becomes understandable in terms of psychodynamics, only when it is understood in its symbolic meaning. During his treatment, the schizophrenic patient stated quite frankly that he, in his regressive state of symbolization, interpreted the behavior of the attendant, so harmless to the rational observer, as a homosexual gesture of seduction. Being aware of his "symbols coming to life," he actually experienced for a moment a crucial upsurge of his psychosis: the breaking through of the unconscious, which is usually the most uncanny experience of all. In my paper, "Laughter in Dreams,"[4] it was shown that, just as in the schizophrenic's reaction, the reason for the laughter is not obvious but can be understood only after the interpretation of the symbolization. Then, in the unconscious, the mechanisms are identical with the dynamics on a conscious level.

The uncanny feeling is experienced when suddenly an old childhood belief of the magic-mystic world of thinking appears to become real. The return of the repressed, of something that had been known once and should remain unknown, is like the sudden reappearance of an old acquaintance who is not welcome but cannot be warded off. The phenomenon of surprise is similar in its psychodynamics: surprise is the sudden recognition of an old childhood expectation which underwent repression. Of the many examples that could well illustrate that even in the moment of greatest surprise only a thing that has for long, but unconsciously, been expected is recognized, I shall report only one here.

A patient took a trip half across the continent and while he was on a lonely beach on one of the Great Lakes, he decided to go swimming. In the water he had the comforting feeling of being alone which suited his mood, when he saw a head popping up and down in the water. Upon swimming closer, he recognized the swimmer, with immense surprise, as an old friend whom he had last seen ten years before on the other side of the ocean. An old childhood expectation: *You cannot be separated from your friends forever —there will be a "see you again" always,* suddenly came true. The suddenness is important because it makes the breaking through of the unconscious so overwhelming. A slow realization usually succeeds in keeping defense barriers intact and rational thinking is not endangered.

In a similar way, a shock is the sudden recognition of an old and repressed

childhood trauma or threat coming true. Probably the first laughter appears when the infant is "shocked" or startled by a sudden noise or threatening movement of an adult; the infant is all set to react with fear and suddenly realizes that it was all in fun. He then discharges his pent-up energy in laughter. The laughter occurs where the situation of a shock is given but where the harmlessness of the threat is suddenly recognized. This interpretation, of course, covers only one aspect of the Comic.

For the sake of completeness, one more phenomenon may be mentioned, although its complexity makes a deeper analysis impossible here: the peculiar sensation called *"deja-vu"* carries with it very clearly a mild undercurrent of the uncanny. It is quite generally felt with little emotion and it goes back to a sudden recognition of a real situation prior to the onset of the childhood amnesia. This recollection is usually related to the actual reality situation; often, however, the analysis shows the connecting link to the deeper layers of the unconscious.

There is one emotion which shows to what power and intensity such recognition of old childhood impressions may lead if reactivated. In the case of fascination, an old childhood ideal or love object (or its representative) is suddenly rediscovered and deeply felt. It shows that the world of childhood experience never dies. This was a world rich in wonder and surprise; no matter how carefully it is repressed, it still forms the true origin and basis for the "Creative Unconscious".

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THE STRANGE CASE OF WILHELM REICH

By MILDRED EDIE BRADY

As far as the editors can determine, the following article by Mildred Edie Brady reprinted from the *New Republic* of May 26, 1947, with the permission of the editors and the author, is a valid presentation of "The Strange Case of Wilhelm Reich." In view of the fact that the author of the article suggested that members of the medical profession had not themselves made sufficient effort to warn the public of their non-approval of Mr. Reich, the editors of the *Bulletin* decided to reprint her article for the benefit of our readers. In the middle and late 1920's, Reich made some important contributions to the theory of psychoanalysis in his numerous papers and book on character analysis. He was expelled from the International Psychoanalytic Association in 1934 because of his complete ideological departure. At the same time his political activities, as described in the following article, had brought him into sharp conflict with all political parties, including the Nazis, the Socialists, and the Communists.

The review by Jules H. Masserman of Reich's latest edition of *Character Analysis*, in *Psychosomatic Medicine*[1] is not an official repudiation of Reich by psychoanalysts. When an individual leaves a scientific field of endeavor, it is hardly customary and certainly unnecessary that workers in the original field should be expected to state their opinions publicly. His present interests, theories and practice involving the orgastic potency theory and the discovery of orgone have nothing to do with psychoanalysis and are not accepted as such by any of the leaders in psychoanalysis today.

The Editors

The psychoanalysts who are assembled in New York this week for the annual meeting of the American Psychiatric Association have reason to congratulate themselves on the flourishing state of their profession. But they are faced with some problems, too, and the most pressing of these is the responsibility of their profession to discipline itself if it is not be be disciplined by the state.

The fact that there are still no legal controls over the practice of psychoanalysis is one that is rarely mentioned in the huge literature dealing with this fascinating field of medicine. Meanwhile, a flood of uncritical popularizations of psychoanalytic concepts has been sweeping over the public via books, magazines, movies and radio. And the readiness of laymen to accept almost any doctrine claiming to be based on psychoanalysis is illustrated by the story of Wilhelm Reich, around whose theories there has already begun to collect a cult of no little influence.

Born in Austria and now a resident of Forest Hills, Long Island, Reich is the framer of the theory of "orgastic potency." He claims as his greatest scientific achievement the discovery of "orgone."

Orgone, named after the sexual orgasm, is, according to Reich, a cosmic

[1] *Psychosomatic Medicine*, 8: 73–74, January, 1946.

energy. It is, in fact, *the* cosmic energy. Reich has not only discovered it; he has seen it, demonstrated it and named a town—Orgonon, Maine—after it. Here he builds accumulators of it which are rented out to patients, who presumably derive "orgastic potency" from it.

Most psychoanalysts look askance at Reich's teachings, yet many of his writings have been discussed in such high places as the *Journal of the American Medical Association* and the *American Journal of Psychiatry*, where his standing in the field of psychoanalytical theory is granted, though his orgone is not. You will also find him listed in *American Men of Science*, and you will find his orgone there, too. Only one scientific journal, *Psychosomatic Medicine*, has so far come out strongly against Reich; it characterized his writings about orgone as "a surrealistic creation."

In the lay press, meanwhile, Reich has received almost entirely uncritical attention. The magazine *Politics* has carried enthusiastic accounts of his social and sexual theories. The *Nation* reviewed his latest book with praise. Even that stern journal of dialectical materialism, *Science and Society*, has recommended him in its pages. Popularized psychoanalytical books like *Modern Woman: The Lost Sex* have quoted generously from him. Avant-garde publications like *Pacifica Views* (San Francisco), *Now* (London) and *Hermes* (Sydney, Australia) have taken up his theories in earnest. The growing group of anarchistically inclined literati on both sides of the Atlantic read him with fervor. Reich's books have been assigned in university seminars for serious consideration and his orgone cult has spread so far that at a camp in New York State last summer it took the doctor's strict orders to keep the camp director from furnishing orgone accumulators for the boys.

Today Reich runs a considerable establishment in his two-story brick house in Forest Hills, and he has more patients than he can take care of. As you climb the stairs to his second-floor office, you find pictures of stellar nebulae along the walls. You find Reich to be a heavy-set, ruddy, brown-haired man of 50, wearing a long white coat and sitting at a huge desk. Between periods of training students in his theories and putting patients into orgone accumulators, he will tell you how unutterably rotten is the underlying character of the average individual walking the streets, and how, in the room across the hall where he works on his patients, he peels back their presentable surfaces to expose the corrupted "second layer" of human personality. For the masses of the people, says Reich, "are endemically neurotic and sexually sick."

Reich has come a long way since his early days in Vienna. In the early nineteen twenties, when he himself was also in his twenties, he was a member of a group of psychoanalysts who met monthly with Freud, and he was for six years the director of the Vienna Seminar for Psychoanalytic Therapy.

In those years he was known as a courageous pioneer in therapeutic techniques.

Two things about psychoanalysis and psychoanalysts bothered him. In the first place, it seemed to him that psychoanalysts were not facing up to their social responsibilities—responsibilities all too clearly implied in their theories, particularly those dealing with the sexual etiology of neuroses and infantile sexuality. And second, he did not feel that they were really shouldering their scientific responsibilities. Freud had said that psychoanalysis would one day have to be rooted in biology, yet here were the analysts spinning a gigantic web of explanations and giving very little time to an objectively demonstrable basis for their assumptions.

So Wilhelm Reich dedicated his energies to filling these two gaps—the social and the scientific. As step number one in the first, he joined the Socialist Party of Austria and began to organize "sex-political" units within that organization. The program for these units, which he described as "sex-economics," was based on his own chief contribution to psychoanalytical theory up to that time.

That contribution is known in the literature as the orgasm theory. Briefly, the orgasm theory is this:

Until Reich, says Reich, it had been naïvely assumed by nearly everybody that the sexual orgasm was nothing more than a tricky bit of sugar coating devised by Mother Nature to make sure that the race survived. Even the analysts, for all their probing into sexual behavior, had strangely overlooked this most significant sexual experience. But Reich centered his attention precisely here and came out with what he terms an answer to a big and bothersome theoretical question: to wit, where did the emotional energy come from which was abortively expressed in neurotic behavior? It had already been assumed that it was sexual energy. But how did it happen to seek non-sexual channels for expression? The orgasm gave the clue. The function of the orgasm, said Reich, was far more important than a lure to procreation. That was simply a sideline use. The real function was to release sexual tension built up by sexual energy. And since, according to accepted psychoanalytical theory, sexual energy was basic energy, the orgasm hence became the body's emotional-energy regulator. Sex economics is the economy of instinctual urges.

When some analysts pointed out that they had dealt with neurotics who *did* experience the orgasm but stayed neurotic all the same, Reich's comeback was: What kind? For he also stipulated that unless the orgasm was adequate to the tension, obviously some energy was not released, and this unspent energy provided the emotional fuel for anxiety, which he defined as the reverse side of the coin—sexuality. The capacity to experience a re-

lease in the orgasm equal to the sexual tension, Reich called orgastic potency.

According to Reich, though, only a very few individuals were blessed with orgastic potency. Society's general anti-sexual attitude, compulsive morality, legally enforced monogamy and family pressures on behalf of premarital chastity had so inhibited man's natural sexuality that most of the world was now peopled, said Reich, with orgastic cripples.

The burden of reshaping society toward sexuality and the promotion of orgastic potency he placed, at that time, on the Socialist Party of Austria.

But the party was unequal to the task. Reich's sex-political units were, needless to say, quite popular. So popular, in fact, that the party fathers began to feel that sex economics was sabotaging Marxian economics and draining off enthusiasm from such problems as the relationship between capital investment and the rate of wages.

So the upshot of this first attempt of Reich's to make psychoanalysis socially responsible was that in 1930 the Socialist Party relieved him and his sex-political units of their party membership.

But he was no easy man to daunt. He went to Berlin to join the German Communist Party and began again to organize sex-political units. Even for the disciplined ranks of the Communists, however, the lure of his teachings proved too strong. And so, according to Reich's own account, on orders from Moscow his theories were condemned as "un-Marxist rubbish" and "bourgeois ideology" and he was kicked out of the party.

Meanwhile, he had been running into trouble on the scientific end as well. Freud himself saw fit to take issue with him, and in 1934 Reich was expelled from the International Psychoanalytical Association.

Hitler having come to power in the meantime, Reich found himself not only out of his scientific fraternity but also out of Germany. Fleeing to Denmark, he set up as a teacher and one of his followers ran for the Danish Riksdag on a sex-political platform that again made Reich the center of attack. The Socialist and Communist Parties in particular accused him of corrupting Danish youth with decadent German sexology. Soon he was denied a renewal of his Danish visa. So he moved on to Sweden—only to run into visa trouble there, too.

The next step took him to Oslo, where for three comparatively quiet years he taught and experimented. With electrodes, amplifiers, oscillographs and all manner of impressive paraphernalia he measured electrical responses on erogenous skin surfaces under sexual excitement. In 1937 he published a paper on some of his findings. He hadn't quite got hold of orgone yet, but he was close: he had discovered something he called *bions*. *Bions*, he said, were a form of primitive life that had developed spontaneously out of non-living matter.

With that paper on *bions* the fireworks were set off again. Physical sci-

entists termed both *bions* and the experiments which he claimed had led to their discovery as utter scientific nonsense. Then the leading liberal paper, *Tidens Tegn*, launched a campaign against him which was joined by scientists and other newspapers, and this led to a royal decree to the effect that anybody practicing psychoanalysis in Norway would have to have a special license from the government.

So, in May, 1939, Wilhelm Reich dismantled his whole biophysical laboratory, said farewell to his European co-workers in sex economics and headed across the Atlantic.

When he arrived in the USA, he was quite a puzzle to the FBI. As late as December, 1941, he was taken out to Ellis Island for three weeks of further investigation. But Reich had long since given up communism. More than that, he had damned Russia in a book, *The Sexual Revolution*. Stalin, according to it, is anti-sex. Russia today is "sex-reactionary," and to Reich this means fascist. The evidence: Russia's strict divorce laws, her laws against abortion, her abandonment of co-education in secondary schools and her official encouragement of large families.

Except for the FBI's confusion, Reich's reception here was cordial. He taught at the New York School for Social Research for two years and he managed to amass enough funds to launch his publishing activities. Soon he was able to announce his discovery of orgone.

In both his *International Journal of Sex-Economy and Orgone Research* and his book, *The Function of the Orgasm*, the romance of orgone is spelled out in polysyllabic detail. Aside from being *the* cosmic energy, it is described as being blue in color and a treatment for cancer. It has many other remarkable qualities, too. In the first place, says Reich, it is everywhere. It is measurable (the unit is an Org). It can be seen with the naked eye. It emanates from the sun. It accounts for the blue of the sky. It kills rot germs. It is in all plant and animal organisms. Both St. Elmo's Fire and the bluish formations astronomers have observed during a period of increased sunspot activity are simply manifestations of orgone energy. All red corpuscles are charged with it. So is plant chlorophyll. All gonadal cells, protozoa and cancer cells consist of these "bluish energy vesicles." The bluish coloration of frogs in sexual excitement, which many biologists, says Reich, have observed, is nothing other than "orgonotic excitation."

But its most astounding property is that it can be collected and concentrated if you know how, and Reich says he does. He has fashioned orgone accumulators which he rents out to his patients.

The orgone accumulator is a six-sided box big enough for a man to get into and made out of metal on the inside and of wood, or some other organic material, on the outside. The organic material presumably absorbs orgone from the air. The orgone then seeps through the metal, thus stepping up

the orgone concentration inside the box. Why it doesn't seep right out again is a mystery that has bothered Reich considerably, and he has not yet solved it.

With orgone Reich has combined in a magical package a group of ideas that resemble both mesmerism and phrenology and has welded the whole together with a persuasive amalgam of psychoanalytical concepts. According to Reich, every living thing is surrounded by a field of orgone which keeps it charged with living energy. The sexual orgasm in the human body, or the cell division in the protozoa, is the agency for the release of this orgonotic charge which, after discharge, builds up again and thus establishes what Reich describes as the basic, pulsating life rhythm of "charge-tension-discharge-release." But when there is inadequate release in the orgasm, the core of the body is kept in tension.

Psychically, says Reich, the "orgastic impotent" is one who is in a state of tension like that of "a bladder about to burst." Pressured by this inner misery, he develops a "character armor" to hold in this tension—thereby succeeding only in making matters worse for himself. In this state of outer rigidity (expressed in muscular tensions) and inner anxiety he becomes "sadistic," "masochistic," "anti-Semitic," "fascistic," "reactionary," "hateful," "submissive," "authoritarian," "greedy," "power-motivated" and "perverse." His best hope of achieving mental health and decent social behavior is for him to relax the "character armor" and give himself a chance at a good orgasm.

Here's where the orgone accumulator comes in. It is a kind of crutch to tide over the depleted tissue until the therapist has time to work on the "character armor" to release the outer rigidities. This phase of Reich's therapy is reminiscent of phrenology. But Reich does more than read the "muscular armoring" by touch. He works on it manually, and chases tension spasms up and down his patient's body—from face to neck, from neck to thorax, from abdomen to thigh, until finally the tension gives way and waves of repressed anxiety are released and break out all over the subject in startling fashion. This technique, which he calls "vegetotherapy," is described in detail in his journal, with harrowing reports of intimate physical responses on the part of patients.

With the discovery of orgone, the orgasm theory became, for Reich and his followers, a demonstrable corroboration of the work of Freud. But now the Reichites go far beyond Freud and declare that orgastic impotence is the primary cause of cancer, all neuroses, all psychoses, impotence, frigidity, perversions, cardiovascular hypertension, hyperthyroidism, constipation, hemorrhoids, epilepsy, peptic ulcer, obesity, narcotic addiction, alcoholism and the common cold.

It would certainly not be fair to lay the whole blame for the growing Reich cult at the door of psychoanalysis itself. But some of it must be

placed just there. The reputable analysts who have quoted him as an authority will tell you that they do not hold with orgone, and that Reich is now discredited among them. But as late as 1945, Otto Fenichel, in the course of his *The Psychoanalytic Theory of Neurosis*, granted Reich considerable standing, and not a few analysts declare that this book of Fenichel's is "the current bible of the American Psychoanalytic Association."

To be sure, Reich himself does not belong to the Association. But no member of the Association has taken pains to make public the current professional evaluation of Reich's work. Undoubtedly, like members of any other profession, psychoanalysts on principle wish to avoid attacking one of their number even though they disapprove of him. But behind the analysts' reticence there may well lie something more significant than professional courtesy. Any open discussion of Reich inevitably leads to a discussion of the chaotic professional and legal status of this whole fast-growing branch of medicine.

It is a singular fact that in most states druggists, plumbers and even hair dressers have to have a license to practise their skills, while anybody can call himself a psychoanalyst, hang out a shingle and take patients. Of course, a psychoanalyst who is not an M.D. is—like anybody else—prohibited from practising medicine. But so long as he sticks to the patient's unconscious conflicts and only listens or talks, the amateur analyst is within the law.

The case of Wilhelm Reich, however, points up a matter that is an even greater problem to psychoanalysis than the legal laxness which allows chiropractors, swamis, spiritualists, etc., to give so-called analytic aid. Before the qualifications for a license for psychoanalysts can be drawn up, a definition of the practice is necessary. But whose definition is correct: The Freudian's, the Jungian's, the Adlerian's, or that of any one of the dozens of deviants from these various stems?

The simplest solution would be to take the current standards of the American Psychoanalytic Association and write them into the law. They are high. They require medical training, hospital experience, analytic training, etc. But these standards were only adopted within the association in 1938; if they became legal requirements, a considerable number of analysts who joined the association before 1938 would be forced out of their profession.

The only answer which established, well trained analysts have been able to give to this question of public protection is the old one of publicity. Educate the public to recognize the unsound practitioner, they say. But such education would appear to call for more hearty coöperation from those recommending it than has been given in the past. And the case of Wilhelm Reich shows how unreliable a reed publicity can be when it, alone, must carry the burden of public protection.

THE INTERNATIONAL CONGRESS ON MENTAL HEALTH

London, August 11–21, 1948

The International Congress on Mental Health to be held in London next summer has been planned to bring together professional workers in the field of psychiatry and mental health and allied disciplines from many nations to begin cooperative mental health planning on a world scale. Representatives from thirty-seven nations have already indicated their intention to be present. These include psychiatrists and other social scientists from not only North and South America, Asia and Western Europe but also the Eastern European countries of Bulgaria, Roumania, Hungary and Czechoslovakia.

Dr. John R. Rees, who was chief psychiatric consultant to the British Army during the war, heads the group of co-workers in London who are preparing for the Congress, and Dr. Frank Fremont-Smith, Medical Director of the Josiah Macy, Jr. Foundation of New York, is directing the work of preliminary organization in this country.

Instead of individual presentations, the program will consist mainly of the reports of numerous discussion groups which are being established in the various participating countries and which will be made up of representatives of several professions, such as psychiatry, social work, psychology, pediatrics, anthropology, nursing and education. In the plan of organization for these groups, the United States is divided into five regions with a chairman for each. These are: northeast region, Miss Marian McBee, New York; southeast region, Dr. George H. Preston, Baltimore; central northwest, Dr. Leo H. Bartemeier, Detroit; central southwest, Dr. Lewis L. Robbins, Topeka; far west, Dr. Martha MacDonald, Palo Alto, Calif. Similar efforts to enlist qualified people interested in social welfare will be made in other countries.

The International Committee for Mental Hygiene, one of the sponsors of the Congress, has proposed the formation of a World Federation for Mental Health to replace the present Committee and the organization of this World Federation with elected delegates from many countries will be one of the tasks of the Congress. The Federation would then apply to UNESCO and the World Health Organization of the United Nations for recognition as the official international voluntary organization in the field of mental health.

High hopes are held for the Congress of which Dr. Fremont-Smith has said, "For the first time psychiatrists in company with representatives of all the other social sciences from all over the world are pooling their knowledge in a common effort to promote harmonious living among all peoples which is an essential basis for world peace."

BOOK REVIEW

Hypnotherapy. By Margaret Brenman and Merton M. Gill. Price $4.50. Pp. 276. New York, International University Press, 1947.

The title of Dr. Brenman's and Dr. Gill's volume, *Hypnotherapy—Survey of the Literature*, gives no indication of the vast amount of original work these authors have included in the book. The book is, in the opinion of the reviewer, one of the most highly significant works available today on hypnotic theory and practice. In addition to its other virtues, it is extremely well-organized and well-written. The first portion of the book which was originally published in monograph form by the Josiah Macy, Jr. Foundation in 1944 benefits by the reprinting, the type being larger and more legible.

Chapter one includes a short review of the historical development of hypnotherapy. This chapter may seem incomplete to the reader; however, succeeding chapters contain supplementary historical material. *Chapter two*, which describes methods of inducing and terminating hypnosis, is a splendid exposition of conventional methods of hypnotic induction and will be appreciated by those who desire to learn the induction technics. *Chapter three* discusses susceptibility to hypnosis, and describes reports which have been published on this subject using various personality inventories and projective materials. *Chapter four* elaborates in detail the various therapeutic applications of hypnosis. In reading this section one can appreciate the tremendous amount of research and documentation that was required to produce so succinct an account of the various existing hypnotherapeutic methods. *Chapter five* contains a dissertation on conventional theories of hypnosis, while *Chapter six* is a summary and a statement of problems.

The second section of the book contains four case studies. These are a valuable addition to the original monograph, indicating the application of hypnoanalytic principles to patients suffering from a variety of syndromes. The psychodynamic material here is as fascinating as it is instructive.

The final section of the book is an experimental study by Dr. Brenman on the use of hypnotic technics in a study of tension systems. This report adds to the accumulating evidence that hypnosis constitutes a most important method for the study of personality functioning.

This book is an extremely valuable text for the psychiatric worker and its merits the highest commendation.

—Lewis R. Wolberg, M. D.

BOOK NOTICES

The Proceedings of the Third Psychotherapy Council. Pp. 176. Chicago, Institute for Psychoanalysis, 1946.

The book's rather business like title does not do justice to its stimulating, rich and controversial content. The reader is acquainted with the discussions of the third meeting of a group of therapists—under the leadership of Dr. Franz Alexander—who are interested in the improvement of therapeutic techniques. The first paper by Alexander describes the treatment of "A Case of Peptic Ulcer and Personality Disorder" while the second one by Dr. Adelaide M. Johnson deals with "A Case of Migraine." Both authors stress the characterological aspects rather than the symptoms.

It is interesting to note that the original stress on brief therapy as opposed to standard analysis has given way to more modest and realistic claims towards a more flexible approach. The brilliant discussions of these two papers touch on almost every controversial subject in relation to therapy, and one is impressed by the general awareness that the efforts towards new and better methods represent also a social reaction to the increased needs and demands of the war and post war era. The third part of the book, a symposium on "The Psychiatric Out-Patient Clinic of the Future", reveals increasing social responsibility by the profession and consists of a hopeful discussion of the possibilities there are. (Rudolf Ekstein, Ph.D).

In Quest of Foster Parents. By DOROTHY HUTCHINSON. Price $2.00. Pp. 145. New York, Columbia University Press, 1943.

The Psychology of Homefinding is the subject of this book which is addressed to social workers interested in the selection of foster homes for children. The book's particular challenge is for understanding of what is involved for the social worker as well as the foster home applicant in the homefinding experience. Miss Hutchinson, a specialist in the field of child placement, writes well; the psychology she expresses is sound and is a reflection of her own warmth and human understanding. The need for the second printing of this book is consistent with the enthusiasm with which it has been hailed from the first by social workers who have found it stimulating and practical in work with adults as well as children. (Lucille Cairns, LLB., M.S.W.).

Counseling Methods for Personnel Workers. By ANNETTE GARRETT. Price $2.00. Pp. 187. New York, Family Welfare Association of America, 1945.

This book emphasizes that area of industrial counseling which overlaps casework. It is directed primarily to the personnel worker without professional preparation for his job. Toward that end it has been well planned, as it is written with a light touch, technical language and casework jargon are avoided, and short case sketches are used frequently. The author adapts her own special skills of casework interviewing to the industrial situation, and attempts to set down knowledge, philosophy and method essential to helping in this kind of setting. She has written a convincing text book and I would expect many mature personnel workers to be stimu-

lated by it to seek further professional education. I wish the author would have used her unique opportunity and excellent knowledge to discuss further the personnel worker's relation to administrative structure, and more of the limits this imposes. (Lucille Cairns).

Aging Successfully. By GEORGE LAWTON. Price $2.75. Pp. 266. New York, Columbia University Press, 1946.

If the recommendations, suggestions and advice in this book were read, taken to heart and patiently and persistently followed by a young person it would do him a world of good in "aging successfully." It is for the person under forty—after that the frozen state of most persons' lives make it almost inapplicable. I recommend it to the young. (C. F. Menninger, M. D.).

Personality and Sociometric Status. By MARY L. NORTHWAY, ESTHER B. FRANKEL and REVA POTASHIN. Price $2.25. Pp. 73. New York, Beacon House, 1947.

Popular and Unpopular Children, A Sociometric Study. By MERL E. BONNEY. Price $2.25. Pp. 81. New York, Beacon House, 1947.

Sociometry of Leadership. By HELEN J. JENNINGS. Price $1.50. Pp. 28. New York, Beacon House, 1947.

Time as a Measure of Inter-Personal Relations. By J. L. MORENO, HELEN H. JENNINGS, AND JOSEPH H. SARGENT. Price $1.25. New York, Beacon House, 1947.

Sociometric Structure of a Veterans' Cooperative Land Settlement. By HENRIK F. INFELD. Price $1.50. Pp. 23. New York, Beacon House, 1947.

Political and Occupational Cleavages in a Hanoverian Village, Germany. By CHARLES P. LOOMIS. Price $1.50. Pp. 17. New York, Beacon House, 1947.

The Research Center for Group Dynamics. By KURT LEWIN. Price $1.50. Pp. 32. New York, Beacon House, 1947.

Seven sociometry monographs from Beacon House cover the wide range of subjects suggested by the titles listed above. Several deal with methodology, several with specific research studies on groups, (such as the population of a small German village, the members of a veterans cooperative land settlement in Saskatchewan, and 150 school children in Denton, Texas, of which the last is by far the most thorough).

Personality and Sociometric Status is a group of four papers from the dept. of psychology at the University of Toronto.

The Research Center for Group Dynamics reprints a paper by the late Kurt Lewin describing the Research Center for Group Dynamics founded by him at the Massachusetts Institute of Technology and also includes an appreciation of his life and work by one of his students and a list of Lewin's writings. (Louisa P. Holt, M.A.).

140 Million Patients. By CARL MALMBERG. Price $2.75. Pp. 236. New York, Reynal & Hitchcock, 1947.

There certainly cannot be any question any more as to the incompleteness of adequate medical coverage in this country. There does seem to be

considerable question as to what should be done about it. The official position of American medicine is that we are making progress and things are rapidly getting better and will ultimately be generally satisfactory. Unfortunately, some spokesmen for the medical profession permit themselves to get into a defensive attitude about this and make totally indefensible statements. The opinion of many laymen is that something more radical must be done. The author of this book takes the latter position, and documents it. (K.A.M.)

The Anatomy of the Nervous System. By STEPHEN WALTER RANSON. Price $6.50. Pp. 531. Philadelphia, W. B. Saunders Co., 1947.

In 1920 the first edition of this textbook appeared, and in 1947 the eighth. This is the first edition to be published since Dr. Ranson's death, and it has been revised by Dr. Sam Clark of Vanderbilt University, a neuroanatomist amply qualified to carry on Dr. Ranson's work. There is little new to be said of a book which has been first in its field for so many years, which has grown steadily through eight editions, and which is well known to almost every medical student in the country. This edition differs from previous ones in none of the essentials, which is to say that it remains clear, concise, and factually reliable. Its organizational changes enhance its usefulness, and it seems slightly better illustrated. In spite of recent more lavishly illustrated and beautifully bound books, it remains the best buy in the field. (Ruth I. Barnard, M.D.).

Myasthenia Gravis. By ADALBERTO R. GŌNI. Pp. 112. Baltimore, Williams & Wilkins, 1946.

This monograph first appeared in Spanish and the present volume is an excellent translation by Georgianna S. Gittinger. In the first portion of this work, Dr. Gōni gives a detailed discussion of the historical, clinical and pathologic aspects of myasthenia gravis. The chapter on pathologic physiology is written with the collaboration of Dr. Alfredo Lanari, who did most of the original research on the action of acetyl choline in myasthenia gravis. The psychology of the neuromuscular synapse and its relation to myasthenia is excellently summarized.

In the second portion of the monograph, the author reports on thirteen cases, which he observed in Buenos Aires since 1937. In the discussion of these cases, the author illustrates the importance of prostigmine as a diagnostic aid and in treatment.

This is the best monograph available on the subject and is highly recommended. (Edward G. Feldman, M.D.)

Families in Trouble. By EARL LOMON KOOS. Price $2.25. Pp. 134. New York, King's Crown Press, 1946.

Belatedly this exemplary report of an exemplary research technique in psychosocial investigation deserves review and commendation to those who seek a blue print for the integration of psychiatry and sociology. It relates to the results of a series of unsolicited interviews with sixty-two families in one neighborhood in New York and an analysis of the "troubles" experienced by them. (K. A. M.).